# Veterans Health Care
# December 2003

1: Am J Cardiol. 2003 Nov 1;92(9):1106-8.
Adherence with statin therapy in secondary prevention of coronary heart disease in veterans administration male population.
Kopjar B, Sales AE, Pineros SL, Sun H, Li YF, Hedeen AN.
This retrospective cohort study enrolled 8,768 male Veterans Administration patients with coronary heart disease who were prescribed statins from July 1, 1999, to June 30, 2000. After 18 months of follow-up, 71% of the patients had been dispensed >or=80% of the medication. Our population's persistence in using statins was higher than in other open-population cohorts but lower than in randomized controlled trials.
PMID: 14583366

2: Am J Gastroenterol. 2003 Oct;98(10):2312-6.
Prevalence of advanced neoplasia at screening colonoscopy in men in private practice versus academic and Veterans Affairs medical centers.
Harewood GC, Lieberman DA.
OBJECTIVES: Several large population studies assessing the yield of average risk screening colonoscopy have evaluated Veterans Affairs (VA) populations. It remains uncertain how generalizable these findings are to men in the general population. The aim of this study was to define the prevalence of advanced neoplasia in male patients undergoing screening colonoscopy in diverse practice settings. METHODS: The Clinical Outcomes Research Initiative (CORI) national endoscopic database was analyzed to compare the findings in men undergoing average risk screening colonoscopy in community, academic, and VA endoscopy settings. RESULTS: Between January, 1998, and May, 2002, a total of 9109 men underwent screening colonoscopy in community (5625), academic (2269), and VA (1215) settings. Overall yield of colonic lesions (mass or polyp >9 mm) on average risk colonoscopy was 5.1%; 5.7% (community), 3.4% (academic), and 5.9% (VA) in each site, respectively. Among patients with lesions identified, multiple lesions >9 mm were less common in academic settings (6.4%) compared to community (12.0%) or VA (8.9%) sites. When adjusting for age and ethnicity on multivariate analysis, colonic lesion detection at VA sites was similar to community settings. However, lesion identification was more likely in both settings (VA: OR = 1.72; community: OR = 1.56) compared to academic centers. CONCLUSIONS: Age- and race-adjusted prevalence of polyps >9 mm in men who receive screening colonoscopy was significantly lower in academic sites compared to VA and community practice sites. One must be cautious in generalizing the findings of male patient studies from academic centers to the entire population.
PMID: 14572585

3: Am J Surg. 2003 Nov;186(5):505-8.
Utilization of laparoscopic antireflux surgery at a single Veterans Affairs facility compared with the Veterans Affairs national trend.
Safadi BY, Kown M, Wren S.
BACKGROUND: The widespread use of laparoscopy in the early 1990s has led to an increase in the utilization of antireflux procedures for the treatment of gastroesophageal reflux disease (GERD). This trend has been observed in the private sector, but not within the Department of Veterans Affairs (VA) health care system. Published data suggest that among patients undergoing antireflux surgical procedures, those in the VA were less likely than those in the private sector to undergo laparoscopic surgery. The objective of this study was to determine the trend in the use of laparoscopic antireflux surgical procedures at our VA facility and compare it with the national VA trend. METHODS: All antireflux operations performed at our VA facility from 1991 to 2002 were recorded along with techniques used. National VA data on the utilization of antireflux procedures from 1991 to 1999 was extracted from a recent publication by Finlayson et al. RESULTS: In contrast to the trend observed nationally across VA hospitals, the rate of utilization of antireflux surgery at our VA facility has increased compared with baseline in 1991. Of 83 fundoplications performed from 1991 to 2002, 76 (92%) were attempted or completed laparoscopically. The conversion rate from laparoscopic to open approach was 6.6%. CONCLUSIONS: We have observed an increase in the utilization of antireflux surgery since 1991 at our VA facility. In addition, most fundoplications were performed laparoscopically. These findings are in contrast to published national VA data. The presence of surgeons with interest in laparoscopy, institutional support, and a dedicated esophageal function laboratory may explain these findings.
PMID: 14599615

4: Am J Surg. 2003 Nov;186(5):514-8.
Patterns of disease and surgical treatment among United States veterans more than 50 years of age with ulcerative colitis.
Longo WE, Virgo KS, Bahadursingh AN, Johnson FE.
BACKGROUND: Ulcerative colitis (UC) is a clinical entity that predominantly affects young adults yet large series of middle age or elderly patients with UC are infrequently reported. The aim of this study is to identify patterns of disease, indications for operation, surgical treatment, and outcome of patients more than 50 years of age who required surgery for UC in Department of Veterans Affairs (DVA) Medical Centers. METHODS: A population-based study on all patients in 159 hospitals of the DVA from 1997 to 2001 was carried out. Data were compiled from several national computerized VA data sets. Supplementary information including demographic information, discharge summaries, operative reports and pathology reports were obtained from local medical records. Patient variables were entered into a computerized database and analyzed using the Pearson chi-square and Fisher's exact tests. Statistical significance is designated as $P < 0.05$. RESULTS: One hundred fifty-eight patients were evaluable. The mean age was 59 years (range 51-81); 99% were male. The mean duration of UC was 23 years (range 2 to 50). One hundred of the 158 patients had proctocolitis; 58 had either left-sided colitis or proctosigmoiditis. The mean dose of prednisone prior to surgery was 20 mg; the mean duration of steroid use was 8 years. The indications for elective surgery were intractability (59%), mass or stricture (27%), and dysplasia (14%). Twenty of the 158 patients (12%) were operated on emergently for either toxic colitis, perforation, or hemorrhage. One hundred three of the 158 underwent proctocolectomy and permanent ileostomy, 55 underwent a restorative proctocolectomy, and underwent a segmental colectomy. Twenty of the 158 patients were found to have dysplasia in

their colectomy specimens; an additional 10 (7%) were found to have invasive cancer. Surgical morbidity was 22%. Overall mortality was 4% (7 of 158); all but 1 death occurred after emergent surgery. Mean hospitalization was 36 days (range 2 to 297). CONCLUSIONS: Restorative proctocolectomy was performed in 36% of veterans more than 50 years of age requiring surgery for UC. The majority required surgery for intractable symptoms. Dysplasia and invasive cancer was found in 18% of patients. Mortality after surgery for acute surgical emergencies remains high.
PMID: 14599617

5: Am J Surg. 2003 Nov;186(5):417-9.
Mentoring: the VA experience.
Neumayer L.
PMID: 14599599

6: Am J Surg. 2003 Nov;186(5):449-54.
Major lower extremity amputations at a Veterans Affairs hospital.
Cruz CP, Eidt JF, Capps C, Kirtley L, Moursi MM.
BACKGROUND: This study was made to evaluate the experience at a Department of Veterans Affairs (VA) hospital with consecutive major lower extremity amputations over a period of 7 years. METHODS: The records of 229 patients (221 male and 8 female) who underwent 296 consecutive major lower extremity amputations (119 above-knee amputations [AKA] and 177 below-knee amputations [BKA]) over a period of 86 months (September 1994 to October 2001) were retrospectively analyzed. All amputations were performed by members of the vascular surgery department. RESULTS: Forty of the 229 patients (17%) eventually required a contralateral amputation, 27 patients (12%) had BKAs that eventually necessitated conversion to AKA, and 44 amputations (15%) required an initialguillotine amputation. The 30-day mortalities for BKA, AKA, and BKA to AKA operations were 12%, 17%, and 7%, respectively. Eighty-eight of the amputations (30%) developed wound complications, and required 137 revisions. Seventy-seven of the amputations (26%) had undergone prior revascularization, of which 31 (48%) had an early failed bypass. The average preoperative ankle/brachial index (ABI) was 0.57. Of the patients undergoing amputation, 97 (42%) complained of rest pain, 91 (40%) complained of claudication, and 158 (69%) had tissue loss or gangrene at the time of their operation. One hundred and forty-six patients (64%) were diabetic. Twenty-two patients (9%) were dialysis dependent and 81 patients (35%) admitted to smoking. Of the known causes of death, 21 resulted from myocardial infarction, 22 from congestive heart failure, 14 from respiratory failure, 13 from disseminated cancer, 10 from sepsis, 7 from stroke, and 6 from renal failure. Preoperative functional status determinations revealed that of 272 patients with enough information to assess functional status, 43 were totally dependent, 97 were partially independent, and 132 were independent. Of the 229 patients, 168 (73%) were ambulatory prior to their amputation, and at the completion of this review only 53 patients (23%) were ambulatory. CONCLUSIONS: Most patients undergoing major lower extremity amputations have many comorbidities; hence morbidity and mortality rates are high, with the most common causes of death being cardiac and respiratory in nature. These data suggest that major lower extremity amputations highlight a very high-risk population with only 39% survival at 7 years, as well as a costly subset secondary to prolonged hospitalization times (average 15 days, range 3 to 105), in addition to the extraordinary cost associated with diminished functional status.
PMID: 14599605

7: Am J Surg. 2003 Nov;186(5):468-71.
Colorectal cancer screening at a Veterans Affairs hospital.
Winkleman BJ, Matthews DE, Wiebke EA.
BACKGROUND: Because of limited resources and common barriers to widespread screening, the Surgery Service of the Indianapolis Veterans Affairs Medical Center has focused its colorectal screening program on patients undergoing hernia repair. Our objective was to examine the success, safety, pathology results, and educational benefit of this nontraditional screening program. METHODS: The study was a retrospective analysis of a prospectively collected database (1991 to 2002). Initial screening colonoscopy was performed on 263 average-risk Veterans Affairs patients, 217 (83%) in conjunction with hernia repair. Visualized polyps were removed or biopsied during colonoscopy and pathology reports for all specimens were examined. Results were compared with published screening studies. RESULTS: Complete colonoscopy, defined as cecal intubation, was performed in 93% of initial screening colonoscopies. There were no major complications, including perforation, excessive bleeding, or death, from colonoscopy. Initial colonoscopy showed adenomas in 67 patients (25%), hyperplastic polyps in 34 (13%), and invasive cancer in 4 (1.5%). Follow-up endoscopies revealed cancer in 2 additional patients, 3 and 5 years after initial screening. CONCLUSIONS: This program is an important training resource for surgical residents. Screening colonoscopy performed in conjunction with hernia repair has produced results consistent with more conventional methods. The Surgery Service at the Indianapolis Veterans Affairs Medical Center is providing colorectal cancer screening with a high degree of safety and success in the face of limited resources and common barriers to implementation of widespread screening.
PMID: 14599608

8: Am J Surg. 2003 Nov;186(5):476-80.
Survival and quality of life after organ transplantation in veterans and nonveterans.
Moore D, Feurer I, Speroff T, Shaffer D, Nylander W, Kizilisik T, Butler J, Awad J, Gorden DL, Chari R, Wright JK, Pinson CW.
BACKGROUND: Some previous studies suggested that transplantation performed in Department of Veterans Affairs (VA) patients was associated with a higher rate of complications and poorer outcomes. We examined more than a decade of experience with solid organ transplantation at a single center and compared VA patients with nonveteran patients to assess long-term patient and graft survival and health-related quality of life (HRQOL). METHODS: Demographic, clinical, and survival data were extracted from a database that included all transplants from January 1990 through December 2002 at Vanderbilt University Medical Center (non-VA) and the Nashville VA Medical Center (VA). The HRQOL was assessed in a subset of patients using the Karnofsky functional performance (FP) index and the Short-Form-36 self-report questionnaire. Data were analyzed by Kaplan-Meier survival and analysis of variance methods. RESULTS: One thousand eight hundred nine adult patients receiving solid organ transplants (1,896 grafts) between 1990 and 2002 were reviewed: 380 VA patients (141 liver, 54 heart, 183 kidney, 2 lung) and 1429 non-VA patients (280 liver, 246 heart, 749 kidney, 154 lung). Mean follow-up time was 46 +/- 1 months. Five-year graft survival for VA and non-VA patients, respectively, was liver 65% +/- 5% versus 69% +/- 3% (P = 0.97); heart 73% +/- 8% versus 73% +/- 3% (P = 0.67); and kidney 76% +/- 5% versus 77% +/- 2% (P = 0.84). Five-year patient survival was liver 75% +/- 5% versus 78% +/- 3% (P = 0.94); heart 73% +/- 8% versus 74% +/- 3% (P = 0.75); and kidney 84% +/- 4% versus 87% +/- 2% (P = 0.21) for VA and non-VA, respectively. In the first 3 years after transplant, the FP scores for VA versus non-VA patients were 85 +/- 2 versus 87 +/- 1 (P = 0.50). The

SF-36 mental component scales were 47 +/- 3 versus 49 +/- 1 (P = 0.39); and the SF-36 physical component scales were 37 +/- 2 versus 38 +/- 1 (P = 0.59), respectively. Longer-term (through year 7) HRQOL scores for VA versus non-VA patients were FP 85 +/- 1 versus 88 +/- 1 (P = 0.17); mental component scales 47 +/- 2 versus 49 +/- 1 (P = 0.29); and physical component scales 35 +/- 2 versus 39 +/- 1 (P = 0.05), respectively. CONCLUSIONS: The veteran patients have similar graft and patient survival as the nonveteran patients. Overall quality of life is similar between veterans and nonveterans during the first three years after transplantation. A trend toward a later decline in the veterans' perception of their physical functioning may stem from the increased prevalence of hepatitis C virus among VA liver transplant recipients, a known factor reducing late HRQOL.
PMID: 14599610

9: Arch Pathol Lab Med. 2003 Dec;127(12):1557-64.
Productivity of Veterans Health Administration laboratories: a College of American Pathologists Laboratory Management Index Program (LMIP) study.
Valenstein PN, Wang E, O'Donohue T; College of American Pathologists Laboratory Management Index Program.
CONTEXT: The Veterans Health Administration (VA) operates the largest integrated laboratory network in the United States. OBJECTIVE: To assess whether the unique characteristics of VA laboratories impact efficiency of operations, we compared the productivity of VA and non-VA facilities. DESIGN: Financial and activity data were prospectively collected from 124 VA and 131 non-VA laboratories enrolled in the College of American Pathologists Laboratory Management Index Program (LMIP) during 2002. In addition, secular trends in 5 productivity ratios were calculated for VA and non-VA laboratories enrolled in LMIP from 1997 through 2002. RESULTS: Veterans Health Administration and non-VA facilities did not differ significantly in size. Inpatients accounted for a lower percentage of testing at VA facilities than non-VA facilities (21.7% vs 37.3%; P <.001). Technical staff at the median VA facility were paid more than at non-VA facilities (28.11/h dollars vs 22.60/h dollars, salaries plus benefits; P <.001), VA laboratories employed a smaller percentage of nontechnical staff (30.0% vs 41.9%; P <.001), and workers at VA laboratories worked less time per hour paid (85.5% vs 88.5%; P <.001). However, labor productivity was significantly higher at VA than at non-VA facilities (30 448 test results/total full-time equivalent (FTE)/y vs 19 260 results/total FTE; P <.001), resulting in lower labor expense per on-site test at VA sites than at non-VA sites (1.79 dollars/result vs 2.08 dollars/result; P <.001). Veterans Health Administration laboratories paid less per test for consumables (P =.003), depreciation, and maintenance than their non-VA counterparts (all P <.001), resulting in lower overall cost per on-site test result (2.64 dollars vs 3.40 dollars; P <.001). Cost per referred (sent-out) test did not differ significantly between the 2 groups. Analysis of 6-year trends showed significant increases in both VA (P <.001) and non-VA (P =.02) labor productivity (on-site tests/total FTE). Expenses at VA laboratories for labor per test, consumables per test, overall expense per test, and overall laboratory expense per discharge decreased significantly during the 6-year period (P <.001), while in non-VA facilities the corresponding ratios showed no significant change. CONCLUSIONS: Overall productivity of VA laboratories is superior to that of non-VA facilities enrolled in LMIP. The principal advantages enjoyed by the VA are higher-than-average labor productivity (tests/FTE) and lower-than-average consumable expenses.
PMID: 14632578

10: Arch Phys Med Rehabil. 2003 Nov;84(11):1642-6.
Rehabilitation needs of an inpatient medical oncology unit.

Movsas SB, Chang VT, Tunkel RS, Shah VV, Ryan LS, Millis SR.
OBJECTIVE: To identify prospectively functional impairments and rehabilitation needs in an acute care medical oncology unit. DESIGN: Prospective cohort study. SETTING: Inpatient medical oncology unit at a Veterans Affairs hospital. PARTICIPANTS: Fifty-five patients admitted over a 6-month period. INTERVENTIONS: Not applicable. MAIN OUTCOME MEASURES: FIM instrument, functionally based physical examination, Rehabilitation Needs Assessment, and Recreational Needs Assessment. RESULTS: On admission, the mean FIM total score was 105 out of 126, the FIM motor score was 72 out of 91, and the FIM cognitive score was 34 out of 35. The functionally based physical examination did not generally correlate with scores obtained on the FIM. Forty-eight (87%) patients had rehabilitation needs on admission. Forty-six (84%) patients had rehabilitation needs on discharge. Rehabilitation Needs Assessment on admission showed deconditioning in 42 (76%) patients; mobility impairment in 32 (58%) patients; a significant decrease in range of motion in 23 (42%) patients; deficits in activities of daily living in 12 (22%) patients; a need for recreational therapy in 7 (13%) patients; potential for benefit from patient education in 30 (55%) patients; and a need for modalities, edema control, or wound care in fever (sic) than 5% of patients. The most commonly requested recreational activity was reading. CONCLUSIONS: Patients admitted to inpatient medical oncology units have many unmet, remediable rehabilitation needs that may not be recognized by nonrehabilitation physicians and other clinical staff. These findings suggest that assessment of medical oncology patients may be enhanced by consultation with rehabilitation medicine specialists.
PMID: 14639564

11: Epidemiol Infect. 2003 Oct;131(2):835-9.
Legionella in the veterans healthcare system: report of an eight-year survey.
Kelly AA, Danko LH, Kralovic SM, Simbartl LA, Roselle GA.
The Veterans Health Administration (VHA) of the Department of Veterans Affairs tracks legionella disease in the system of 172 medical centres and additional outpatient clinics using an annual census for reporting. In fiscal year 1999, 3.62 million persons were served by the VHA. From fiscal year 1989-1999, multiple intense interventions were carried out to decrease the number of cases and case rates for legionella disease. From fiscal year 1992-1999, the number of community-acquired and healthcare-associated cases decreased in the VHA by 77 and 95.5% respectively (P = 0.005 and 0.01). Case rates also decreased significantly for community and healthcare-associated cases (P = 0.02 and 0.001, respectively), with the VHA healthcare-associated case rates decreasing at a greater rate than VHA community-acquired case rates (P = 0.02). Over the time of the review, the VHA case rates demonstrated a greater decrease compared to the case rates for the United States as a whole (P = 0.02). Continued surveillance, centrally defined strategies, and local implementation can have a positive outcome for prevention of disease in a large, decentralized healthcare system.
PMID: 14596523

12: Health Phys. 2003 Nov;85(5 Suppl):S78-80.
Radiation safety compliance issues at affiliated institutions.
Michel R, Zorn MJ.
"Affiliation" may be defined as a collaborative interaction between two (or more) organizations in a spirit of mutual benefit through an equitable contribution of resources. Across the United States, hundreds of medical schools and healthcare organizations affiliate with one another for the enhancement of patient care, education, and research. Oftentimes, both parties in the affiliation have active clinical

and research programs that involve the use of radioactive material (RAM). The combination of this close affiliation and use of radioactive material presents a number of challenging radiation safety compliance issues. It is important for radiation safety professionals (RSPs) employed by each affiliate to work together to ensure compliance with applicable regulatory requirements.
PMID: 14570258

13: Health Serv Res. 2003 Oct;38(5):1319-37.
Case-mix adjusting performance measures in a veteran population: pharmacy- and diagnosis-based approaches.
Liu CF, Sales AE, Sharp ND, Fishman P, Sloan KL, Todd-Stenberg J, Nichol WP, Rosen AK, Loveland S.
OBJECTIVE: To compare the rankings for health care utilization performance measures at the facility level in a Veterans Health Administration (VHA) health care delivery network using pharmacy- and diagnosis-based case-mix adjustment measures. DATA SOURCES/STUDY SETTING: The study included veterans who used inpatient or outpatient services in Veterans Integrated Service Network (VISN) 20 during fiscal year 1998 (October 1997 to September 1998; N = 126,076). Utilization and pharmacy data were extracted from VHA national databases and the VISN 20 data warehouse. STUDY DESIGN: We estimated concurrent regression models using pharmacy or diagnosis information in the base year (FY1998) to predict health service utilization in the same year. Utilization measures included bed days of care for inpatient care and provider visits for outpatient care. PRINCIPAL FINDINGS: Rankings of predicted utilization measures across facilities vary by case-mix adjustment measure. There is greater consistency within the diagnosis-based models than between the diagnosis- and pharmacy-based models. The eight facilities were ranked differently by the diagnosis- and pharmacy-based models. CONCLUSIONS: Choice of case-mix adjustment measure affects rankings of facilities on performance measures, raising concerns about the validity of profiling practices. Differences in rankings may reflect differences in comparability of data capture across facilities between pharmacy and diagnosis data sources, and unstable estimates due to small numbers of patients in a facility.
PMID: 14596393

14: J Investig Med. 2003 Sep;51(5):258-9.
Protection of human research subjects.
[No authors listed]
PMID: 14577515

15: J Manag Care Pharm. 2003 Sep-Oct;9(5):401-7.
Weight uniformity of split tablets required by a Veterans Affairs policy.
Polli JE, Kim S, Martin BR.
OBJECTIVE: To split several tablet products relevant to the Veterans Affairs (VA) Maryland Healthcare System and assess whether the resulting half tablets provide equal doses. METHODS: From a VA list of products that are required to be split, 7 products were evaluated, along with 5 other commonly split tablet products. A trained pharmacy student split tablets using a tablet splitter provided by the VA. Half tablets were assessed for weight uniformity. RESULTS: Of the 12 products subjected to splitting, 8 products (atorvastatin, citalopram, furosemide, glipizide, metoprolol, paroxetine, sertraline, and warfarin) yielded half tablets that passed the weight-uniformity test. The 4 failing products were lisinopril, lovastatin, rofecoxib, and simvastatin. Unusual tablet shape and high tablet hardness predisposed products to

failing the weight-uniformity test. The 4 failing products resulted in half tablets that were generally within 20% of their target weight range, suggesting that splitting these specific products would not result in adverse therapeutic effects due to dose variation created by tablet-splitting. CONCLUSION: Split-tablet results were relatively favorable and generally support a VA practice to split specific tablets. Public quality standards for half tablets, including their content uniformity, are needed to better delineate the policies for acceptable tablet splitting.
PMID: 14613437

16: J Manag Care Pharm. 2003 Jul-Aug;9(4):317-26.
Early switch and early discharge opportunities in intravenous vancomycin treatment of suspected methicillin-resistant staphylococcal species infections.
Parodi S, Rhew DC, Goetz MB.
BACKGROUND: Patients with methicillin-resistant Staphylococcus aureus (MRSA) and methicillin-resistant coagulase negative staphylococci (MR-CoNS) infections are usually treated with intravenous (IV) vancomycin and remain hospitalized for the duration of IV therapy. Oral linezolid has excellent bioavailability and activity against MRSA and MR-CoNS and offers the potential for outpatient treatment of MRSA and MR-CoNS infections. OBJECTIVE: To determine the potential for early switch (ES) from IV vancomycin to oral linezolid and subsequent early discharge (ED) in hospitalized, adult patients treated for an MRSA or MR-CoNS infection. METHODS: We conducted a retrospective cohort study at the Veterans Administration Greater Los Angeles Healthcare System from January 1 through December 31, 2000. Potential reductions in vancomycin use, hospital length of stay (LOS), and economic savings were determined. RESULTS: A total of 103 of 177 (58%) treatment courses for MRSA or MR-CoNS infections were potentially eligible for ES, with annual and mean decreases in vancomycin use of 535 defined daily doses and 5.2 days per event. Of the ES cohort, 55 of 103 (53%) courses were potentially eligible for ED, with an annual and mean reduction in LOS of 181 days and 3.3 days per event. The total potential savings was $220,181, at an average of $3,478 per event. CONCLUSION: Early switch to oral linezolid for treatment of MRSA or MR-CoNS infections could reduce vancomycin use, hospital length of stay, and economic costs.
KEYWORDS: Oxazolidanone, Vancomycin, Length of stay, Methicillin resistance, Staphylococcal infections
PMID: 14613450

17: J Natl Cancer Inst. 2003 Nov 5;95(21):1570-2.
VA system a model for health care, experts say.
Twombly R.
PMID: 14600085

18: J Nurses Staff Dev. 2003 Sep-Oct;19(5):253-7.
Healthcare information systems: education lessons learned.
Husting PM, Cintron L.
The educator is a key person during the implementation of a new healthcare computer system or a new software program. Computers require teamwork across departmental lines and flexibility in instructional approach. The authors share their experiences as educators at the San Francisco VA during the initiation of several new computer software packages. They examine the issues involved in this type of training and share the lessons learned.
PMID: 14581834

19: Med Care. 2003 Nov;41(11):1221-32.
Racial disparities in diabetes care processes, outcomes, and treatment intensity.
Heisler M, Smith DM, Hayward RA, Krein SL, Kerr EA.
BACKGROUND: Black Americans with diabetes have a higher burden of illness and mortality than do white Americans. However, the extent to which differences in medical care processes and treatment intensity contribute to poorer diabetes outcomes is unknown. OBJECTIVE: To assess racial disparities in the quality of diabetes care processes, intermediate outcomes, and treatment intensity. METHODS: We conducted an observational study of 801 white and 115 black patients who completed the Diabetes Quality Improvement Project survey (response rate=72%) in 21 Veterans Affairs (VA) facilities using survey data; medical record information on receipt of diabetes services (A1c, low-density lipoprotein [LDL], nephropathy screen, and foot and dilated eye examinations), and intermediate outcomes (glucose control measured by A1c; cholesterol control measured by LDL; and achieved level of blood pressure); and pharmacy data on filled prescriptions. RESULTS: There were no racial differences in receipt of an A1c test or foot examination. Blacks were less likely than whites to have LDL checked in the past 2 years (72% vs. 80%, P<0.05) and to have a dilated eye examination (50% vs. 63%, P<0.01). Even after adjusting for patients' age, education, income, insulin use, diabetes self-management, duration, severity, comorbidities, and health services utilization, racial disparities in receipt of an LDL test and eye examination persisted. After taking into account the nested structure of the data using a random intercepts model, blacks remained significantly less likely to have LDL testing than whites who received care within the same facility (68% vs. 83%, P<0.01). In contrast, there were no longer differences in receipt of eye examinations, suggesting that black patients were more likely to be receiving care at facilities with overall lower rates of eye examinations. After adjusting for patient characteristics and facility effects, black patients were substantially more likely than whites to have poor cholesterol control (LDL > or =130) and blood pressure control (BP > or =140/90 mm Hg) (P<0.01). Among those with poor blood pressure and lipid control, blacks received as intensive treatment as whites for these conditions. CONCLUSIONS: We found racial disparities in some diabetes care process and intermediate outcome quality measures, but not in intensity of treatment for those patients with poor control. Disparities in receipt of eye examinations were the result of black patients being more likely to receive care at lower-performing facilities, whereas for other quality measures, racial disparities within facilities were substantial.
PMID: 14583685

20: Med Care. 2003 Nov;41(11):1256-61.
Racial variations in dental procedures: the case of root canal therapy versus tooth extraction.
Kressin NR, Boehmer U, Berlowitz D, Christiansen CL, Pitman A, Jones JA.
BACKGROUND: Racial disparities have been widely documented in medical care, but variations in dental care have not been well examined. OBJECTIVES: To determine if there is racial variation in use of root canal therapy versus tooth extraction across different levels of dental insurance coverage and adjusting for other factors known to influence treatment decisions. METHODS: Within 3 different categories of insurance coverage, we examined whether there were racial differences in the provision of the tooth-sparing treatment of root canal therapy (vs. tooth extraction) among 54,423 users of outpatient Veterans Affairs dental care in 1998. Regression analyses adjusted for the severity of tooth- and gum-related disease, age, sex, medical and psychiatric comorbidities, prior use of preventive dental services, tooth extraction

and root canal therapy, and clustering by geographic region. RESULTS: In the adjusted regression models, black patients and those with unknown race were less likely overall to receive root canal therapy than whites, whereas Asians were more likely. Among patients with eligibility for continuing and comprehensive dental care, blacks were less likely and Asians more likely to receive root canals than whites. For patients covered only for emergency dental care, Hispanics had a higher likelihood of receiving root canal therapy. Among all other types of coverage, there were no significant racial differences in the care received. CONCLUSION: We observed substantial racial variations in the provision of root canal therapy among patients treated in Department of Veterans Affairs dental clinics. Future research should identify the causes of such variations.
PMID: 14583688

21: Nurs Manage. 2003 Oct;Suppl:18-20.
Barcoding makes its mark on daily practice.
Heinen MG, Coyle GA, Hamilton AV.
PMID: 14574181

22: Urology. 2003 Nov;62(5):918-21.
Factors influencing the outcomes of penile prosthesis surgery at a teaching institution.
Lotan Y, Roehrborn CG, McConnell JD, Hendin BN.
OBJECTIVES: To evaluate the long-term outcomes of penile prosthesis surgery at a teaching institution. METHODS: Patients who had penile prosthesis surgery from 1988 to 1999 at a private teaching hospital and the Dallas Veterans Affairs Medical Center were identified and charts abstracted for age at first prosthesis, ethnicity, etiology of impotence, comorbid medical disease, previous treatments, surgeon, type of prosthesis, perioperative complications, social history, and outcome. Patient outcomes were determined either from recent clinical documentation within the prior year or by telephone survey of patients. Frequent implanters were defined as those surgeons who performed more than 10 procedures during the study period. Kaplan-Meier curves were used to evaluate survival for patients and prostheses; statistical significance was assessed by the log-rank test. RESULTS: A total of 152 patients were identified, 81 patients at the Veterans Affairs Medical Center and 71 patients at the private hospital. A total of 180 procedures were performed by 15 attending surgeons, 4 of whom performed most (n = 132) of these procedures. No statistically significant difference was noted in patient age between the two hospitals. No statistically significant differences were found in survival of the penile prostheses on the basis of a history of smoking, diabetes, hypertension, or coronary artery disease. First prostheses had statistically significant better survival compared with secondary prostheses (5-year rate 71% versus 42%; 10-year rate 60% versus 35%, P = 0.0002). The overall infection rate at final follow-up was 9.9% and 18.8% for primary and secondary prostheses, respectively (P = 0.03). The 5-year survival outcomes with first prostheses for frequent implanters were superior to those of infrequent implanters (70% versus 63%, P = 0.034). Malleable prostheses had fewer complications than three-piece inflatable prostheses (10-year survival rate 87% versus 50%, P = 0.0081). CONCLUSIONS: Superior penile prosthesis outcomes were achieved with first penile prostheses when implanted by higher volume implanters. Meticulous technique and experience are important in all penile prosthesis surgery; however, outcome analysis emphasizes that the differences in outcomes are most apparent with first prostheses, which represent the best opportunity for the patient to achieve good results.
PMID: 14624920

23: Value Health. 2003 Sep-Oct;6(5):566-73.
Medication compliance feedback and monitoring in a clinical trial: predictors and outcomes.
Cramer J, Rosenheck R, Kirk G, Krol W, Krystal J;
OBJECTIVE: The objective of this study was to demonstrate the utility of continuous monitoring and enhancement of medication compliance during a long-term clinical trial, predictors of compliance, and relationships to drinking outcomes. METHODS: Alcohol-dependent patients enrolled in a multicenter VA cooperative study were randomly assigned to once-daily naltrexone (NTX) for 3 or 12 months (short-term or long-term NTX) or placebo for 12 months of treatment. All medications were dispensed in bottles with medication event monitoring (MEMS, AARDEX, Union City, CA) caps with a microprocessor that recorded openings as presumptive doses. Patients were trained to develop personal cues as dosing reminders. Monthly feedback sessions included review of compliance data and cues. RESULTS: There were no significant differences among short-term NTX, long-term NTX, and placebo (209 each) groups in measures of compliance. Overall compliance rates were 71% +/- 31% of doses for the first 13 weeks and 43% +/- 33% of doses over 52 weeks. Some doses were taken during 83% +/- 27% of the first 13 weeks. Higher medication compliance predicted fewer drinks per drinking day (P = .02) throughout follow-up and a lower percentage of drinking days (P = .002 during the first 13 weeks) with no significant effect for treatment group. CONCLUSIONS: The feedback and monitoring programs were important features to demonstrate that lack of treatment effect was not a result of poor compliance. Medication compliance data supported the internal validity of the trial by demonstrating that good compliers had better outcomes, irrespective of treatment with NTX or placebo. The MEMS feedback methodology is feasible for use in multicenter trials.
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